VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

February 20, 2013

Mr. Francis Cheney, Jr., Administrator
Pines Rehab & Health Center
601 Red Village Road
Lyndonville, VT 05851-9068

Provider #: 475044

Dear Mr. Cheney, Jr.:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **January 30, 2013.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:ne

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/06/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475044	A. BUILDING _____ B. WING _____	01/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINES REHAB & HEALTH CTR	601 RED VILLAGE ROAD LYNDONVILLE, VT 05851

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced on-site recertification survey was conducted by the Division of Licensing and Protection from 1/28/13 through 1/30/13. Based on information gathered, the following regulatory violations were cited.	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to ensure services provided met professional standards of quality for 1 of 22 residents in the stage 2 sample regarding Licensed Practical Nurse scope of practice (Resident # 43). Findings include Per record review on 1/29/13 at 2:49 P.M., Resident #43 was found deceased, and pronounced as such by a Licensed Practical Nurse (LPN). A nursing note written by an LPN dated 1/18/13, 10 PM-6 AM (shift) stated that the resident had no pulse, no respirations and no heartbeat. There is no evidence in the clinical record of a physician order for a Registered Nurse (RN) to pronounce. There is no evidence that the resident was assessed by an RN. On 1/29/13 at 3:20 PM, the Director Of Nurses (DNS) confirmed that the 10 PM-6 AM nursing note of 1/18/13 was signed by an LPN and that an LPN had pronounced the resident deceased. The DNS confirmed that the resident was not	F 281	See POC ~ completion date of 2.18.13	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Frances C Cheney | Administrator/Owner | 2-15-2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PMC

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F 281	Continued From page 1 assessed by an RN after being found apparently deceased. The DNS stated it is facility policy that an LPN may pronounce a resident dead. Reference: Vermont State Board of Nursing. Determining Scope of Practice, Position Statement and Decision Tree. http://vtprofessionals.org/opr1/nurses/position_statements/PS-Determining%20Scope%20of%20Practice%20plus%20Decision%20Tree.pdf. Accessed January 23, 2013. The Vermont Statutes Online. Title 26: Professions and Occupations. Chapter 28: Nursing. http://www.leg.state.vt.us/statutes/fullchapter.cfm?Title=26&Chapter=028. Accessed January 23, 2013. Vermont State Board of Nursing. Role of the Registered Nurse in the Pronouncement of Death, Position Statement. http://vtprofessionals.org/opr1/nurses/position_statements/PS-Role%20of%20the%20RN%20in%20the%20Pronouncement%20of%20Death.pdf. Accessed January 23, 2013.	F 281		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all	F 431	See POC = completion date of 2.18.13	

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F 431	Continued From page 2 controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation during medication storage review, the facility failed to assure that medications were disposed of according to the recommended time frame on 1 of 3 wings of the facility. Findings include: Per observation on 1/30/13 at 9:35 AM, the medication cart located on C wing contained vials	F 431		

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F 431	Continued From page 3 of insulin currently in use for residents that were past the recommended discard date. A vial of Novolog Insulin 100 Units/ML in use for Resident #82 was opened on 12/28/12, and was currently in use 33 days after opening. Resident #71 had a vial of Novolog 100 Units/ML currently in use that was opened on 11/29/12, 62 days after opening the vial. The manufacturer's and the pharmacy's recommendation states that Novolog Insulin is to be discarded 30 days from the date of opening the vial. Per interview on 1/30/13 at 9:35 AM, the Nursing Supervisor confirmed that the insulin vials should have been disposed of after 30 days of use.	F 431		
F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility regarding scope of Licensed Practical Nurse (LPN) practice for 1 of 22 Residents in the Stage 2 sample. Findings include:	F 492	See POC & completion date of 2-18-13	

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F 492	Continued From page 4 Per record review on 1/29/13 at 2:49 P.M., Resident #43 was found deceased and pronounced as such by a Licensed Practical Nurse (LPN). A nursing note written by an LPN dated 1/18/13, 10 PM-6 AM (shift) stated that the resident had no pulse, no respirations and no heartbeat. There is no evidence in the clinical record of a physician order for a Registered Nurse (RN) to pronounce. There is no evidence that the resident was assessed by an RN. On 1/29/13 at 3:20 PM, the Director Of Nurses (DNS) confirmed that the 10 PM-6 AM nursing note of 1/18/13 was signed by an LPN and that an LPN had pronounced the resident deceased. The DNS confirmed that the resident was not assessed by an RN after being found apparently deceased. The DNS stated it is facility policy that an LPN may pronounce a resident dead. References: Vermont State Board of Nursing. Determining Scope of Practice, Position Statement and Decision Tree. http://vtprofessionals.org/opr1/nurses/position_statements/PS-Determining%20Scope%20of%20Practice%20plus%20Decision%20Tree.pdf. Accessed January 23, 2013. The Vermont Statutes Online. Title 26: Professions and Occupations. Chapter 28: Nursing. http://www.leg.state.vt.us/statutes/fullchapter.cfm?Title=26&Chapter=028. Accessed January 23, 2013.	F 492		

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F 492	Continued From page 5 Vermont State Board of Nursing. Role of the Registered Nurse in the Pronouncement of Death, Position Statement. http://vtprofessionals.org/opr1/nurses/position_statements/PS-Role%20of%20the%20RN%20in%20the%20Pronouncement%20of%20Death.pdf. Accessed January 23, 2013.	F 492		
F9999 SS=D	FINAL OBSERVATIONS Per Vermont Licensing and Operating Rules for Nursing Homes regulation 5.3 (b) Accuracy of Assessments: Each assessment must be conducted or coordinated by a registered nurse who signs and certifies the completion of the assessment. Based on record reviews and interviews, the facility failed to assure that the assessment for 1 of 22 residents in the sample (Resident #43) was conducted or coordinated by a Registered Nurse who signs and certifies the completion of the assessment. Findings include: Per record review on 1/29/13 at 2:49 P.M., Resident # 43 was found deceased and pronounced as such by a Licensed Practical Nurse (LPN). A nursing note written by an LPN dated 1/18/13, 10 PM-6 AM (shift) stated that the resident had no pulse, no respirations and no heartbeat. There is no evidence in the clinical record of a physician order for a Registered Nurse (RN) to pronounce. There is no evidence that the resident was assessed by an RN. On 1/29/13 at 3:20 PM, the Director Of Nurses (DNS) confirmed that the10 PM-6 AM nursing note of 1/18/13 was signed by an LPN and that	F9999	See POC & completion date of 2.18.13	

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F9999	Continued From page 6 an LPN had pronounced the resident deceased. The DNS confirmed that the resident was not assessed by an RN after being found apparently deceased. The DNS stated it is facility policy that an LPN may pronounce a resident dead.	F9999		

The Pines Rehabilitation and Health Center
Plan of Correction
Survey Completed on 01/30/2013

F 281 483.20(k)(3)(i) Services Provided Meet Professional Standards

The facility failed to ensure services provided met professional standards of quality for 1 of 22 residents regarding LPN scope of practice (Resident # 43).

I. **Action taken to correct the deficiency:**

1. The Facility policy on 'death pronouncement' was changed on 01/30/2013 to reflect the Vermont State Nursing Board's 'Opinion Statement' that LPN's may not pronounce death.

2. All LN's were informed of the change in policy on 01/30/2013.

3. Currently (and prior to survey) the protocol is to notify the DON of all deaths either in person or via telephone. Starting on 01/30/2013 if there is no RN on duty at the time of death, the closest RN will be called in to pronounce.

II. **Corrective actions monitored so that deficiency does not recur:**

1. The DON has, and will be notified of all deaths on an ongoing basis; However; now she will ensure that a RN is available for pronouncement and will review the record to ensure proper procedures were followed.

All residents have the potential to be affected.
Completion date 02/18/2013

Diana LaFountain, RN/DON is responsible for the correction of this deficiency.
F281 POC accepted 2/19/13 JHosmer RN Surv

F 431 483.60(b)(d)(e) Drug Records, Label/Store Drugs Biologicals

The facility failed to assure that medications were disposed of according to the recommended timeframe on 1 of 3 wings of the facility for residents' #82 & #71.

I. **Action taken to correct the deficiency:**

1. The outdated prn Novolog was thrown out on 01/30/2013.

2. A new procedure was put in to place on 01/31/2013 for new single resident

Multi-dose vials. The LN that opens the new medication will date it and put the disposal date on the MAR as a reminder to discard the medication.

II. **Corrective actions monitored so that deficiency does not recur:**

1. Supervisors will check medication carts weekly for outdated medications on an ongoing basis.

All residents have the potential to be affected.
Completion date 02/18/2013

Diana LaFountain, RN/DON is responsible for the correction of this deficiency.

F431 POC accepted 2/19/13 JHosmerRN/ PMC

F 492 483.75(b) Comply with Federal/State/Local Laws/Prof STD

The facility failed to operate and provide services according to accepted professional standards and principles that apply to professionals providing services in such a facility regarding scope of LPN practice for 1 of 22 residents (Resident #43) who was pronounced dead by a LPN.

I. **Action taken to correct the deficiency:**

1. Nothing can be done for resident #43. The resident was a DNR/DNI, was expected to die, was found dead with dependent lividity, the DON and MD was notified of the death and an MD order was obtained for release of the body to the funeral home.
2. The Pines Policy & Procedure was changed on 01/30/2013 to reflect the Vermont State Board of Nursing's 'Opinion statement' that LPN's may not pronounce death.
3. All LN's were informed of the change in policy on 01/30/2013.
4. Currently (and prior to survey) the protocol is to notify the DON of all deaths, either in person or via telephone; and starting on 01/30/2013, if there is not a RN on duty at the time of death, the closest RN will be called in to pronounce.

II. **Corrective actions monitored so that deficiency does not recur:**

1. DON has, and will continue to be notified of all deaths on an ongoing basis; however, now she will ensure that a Registered Nurse will be available for pronouncement and will review record to ensure proper procedures were followed after every death.

All residents have the potential to be affected.
Completion date 02/18/2013
Diana LaFountain, RN/DON is responsible for the correction of this deficiency.

F492 POC accepted 2/19/13 JHosmerRN/ PMC

F 9999 Final Observations

The facility failed to assure that 1 of 22 residents (Resident #43) was conducted or coordinated by a Registered Nurse who signs and certifies completion of the assessment.

I. **Action taken to correct the deficiency:**

1. Nothing can be done for the record of resident #43 at this time. The DON and the MD did coordinate the procedure and the MD did sign the physicians order to release the body to the funeral home.
2. The Pines Policy & Procedure was changed on 01/30/2013 to reflect the Vermont Board of Nursing's 'Opinion Statement' that LPN's may not pronounce death.
3. All LN's were informed of the change in policy that includes that RN's must sign and certify the completion of the assessment.

II. **Corrective actions monitored so that deficiency does not recur:**

1. The DON will continue to be notified of all deaths on an ongoing basis, and now will ensure(as of 01/30/2013) that a Registered Nurse will be available for pronouncement and to sign and certify the completion of the assessment on an ongoing basis as needed.

All residents have the potential to be affected.
Completion date 02/18/2013

Diana LaFountain RN/DON is responsible for the correction of this deficiency.

F9999 POC accepted 2/19/13 JHosmerRN/PMC

Frances E Chamberlain
Administrator/Owner
2-15-2013